First Health Services Corporation

Drug Prior Authorization Request Form (MAP-82101, revised 10/18/04)

Submitted by: [ ] Prescriber [ ] Pharmacy

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to **800-365-8835** (toll free)

For **URGENT** Requests Only, FAX to **800-421-9064** (toll free)
For **NURSING FACILITY** Requests Only, FAX to **800-453-2273** (toll free)

MAIL to PA Unit, 14955 Heathrow Forest Pkwy. Houston, TX 77032
Put return address below:

REQUEST TYPE (please check): ☐ **PRIOR AUTHORIZATION** ☐ **MEDICARE PART B OVERRIDE** ☐ **QUANTITY LIMIT OVERRIDE**
☐ **OTHER** _____

RECIPIENT NAME	MAID # (10 digits)	DATE OF BIRTH
	_ _ _ _ _ _ _ _ _ _	

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
State License# (Not DEA# or Any other #)		

	Drug Requested (Use separate form to request more than 4 drugs.)	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)
1							
2							
3							
4							

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] YES [ ] NO [ ] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

_____

MEDICAL JUSTIFICATION (including drugs already tried)_____

_____

_____

MEDICARE PART B REQUEST REASON (PLEASE CHECK ONE): (A copy of the Medicare EOB denying coverage must accompany each request)

☐ RECIPIENT IS NOT MEDICARE PART B ELIGIBLE
☐ OTHER (PLEASE EXPLAIN ABOVE)
☐ RECIPIENT IS TAKING THE MEDICATION FOR AN INDICATION THAT IS NOT COVERED BY MEDICARE
☐ DRUG DOES NOT MEET MEDICARE COVERAGE CRITERIA

	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	
DRUG #3	
DRUG #4	